General

Guideline Title

UK national guidelines on safer sex advice.

Bibliographic Source(s)

Clinical Effectiveness Group. UK national guidelines on safer sex advice. London (UK): British Association for Sexual Health and HIV; 2012 Jul. 32 p. [120 references]

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The levels of evidence (I-IV) and grades of recommendation (A-C) are defined at the end of the "Major Recommendations" field.

Identifying Candidates for Safer Sex Advice and Other Prevention Interventions

Sexual history taking should be structured to identify risk factors for sexual ill health, sexual practices and behaviours and opportunities for brief behaviour change interventions (IV, C).

Evidence for Behaviour Change Interventions

Intensive multi-session, evidence based behaviour change interventions targeting individuals and focussing upon skills acquisition, enhancing communication skills and increasing motivation to adopt safer sexual behaviours should be available directly or by referral in all genitourinary medicine (GUM) clinics (Ia, A).

Motivational interviewing techniques should be used as part of an intensive course of risk reduction counseling in men who have sex with men (MSM) at high risk of human immunodeficiency virus (HIV) infection (Ib, A).

Brief (15-20 minute) evidence based behaviour change interventions targeting individuals and focussing upon skills acquisition, enhancing communication skills and increasing motivation to adopt safer sexual behaviours using techniques such as Motivational Interviewing should be provided as part of routine care of those at elevated risk of sexually transmitted infection (STI) and HIV in GUM clinics (Ib, A).

The delivery of safer sex advice, including condom demonstration, based on the characteristics of effective brief behaviour change interventions, should be part of the routine care of all those at continued risk of infection/transmission in GUM clinics (III, B).

The provision of accurate, detailed and tailored information on safer sex should form part of all sexual health consultations (IV, C).

Motivational interviewing should be provided by clinic staff who have gained competency in its provision through training. (IV, C).

Intervention Delivery

Computer assisted interventions are comparable in effect and should be considered as an alternative or adjunct to human delivered interventions (Ib, A).

Videos shown in waiting rooms should be considered as an additional aid to promoting behaviour change (IIb, B).

Safer Sex Advice

Condom Efficacy

100% use of the male latex condom should be recommended to all those at risk of STIs including HIV (III, B).

Non-latex condoms are an acceptable alternative to male latex condoms for vaginal sex but have higher rates of breakage (Ia, A).

Female condoms are (at least) equivalent to male latex condoms in the prevention of STIs and should be offered as an alternative or supplement to male condoms to all women (Ib, B).

Men should be made aware of the availability and use of female condoms (IV, C).

Female condoms can be used as an alternative to male condoms for anal sex but are preferred to latex male condoms by a minority of MSM who have used them (IIb, B).

Determinants of Condom Effectiveness

Less than 100% condom use will offer some protection – advise that using condoms as much as possible is better than not at all (IIb, B).

MSM should be advised that thicker condoms are no less likely than standard condoms to break or slip off than standard condoms during anal sex (Ib, A).

Non-oil based lubricant should be applied all over the condom and inside the anus, but not inside the condom, before anal sex (Ib, A).

There is no advantage, in terms of condom safety, in the routine use of lubricant use for vaginal sex (IIb, B).

Both men and women should be instructed on the correct use of male condoms and the importance of applying a condom before penetration and avoiding early removal (IIb, B).

Providing a range of condom sizes is a quick and more practical alternative to formal condom sizing (IV, C).

Motivation for Condom Use

Advice should be based on an exploration of reasons for condom use and recognise that for heterosexual couples, the avoidance of pregnancy rather than STI is a major motivator (III, B).

Advice on Oral Sex

Safer sex advice should include information on the risks of oral sex, recognising that individuals must make an informed decision on the level of risk that is acceptable to them, and supporting pragmatic alternative risk reduction techniques. The risk of transmission of bacterial and viral STIs including HIV applies to both oral and genital partners but the risk to the genital partner is thought to be considerably lower. The risks of transmission associated with oral sex are (considerably) lower than for unprotected vaginal or anal sex except in the case of herpes simplex virus 1 (HSV-1). Advice on further reducing risk includes:

- Avoiding oral sex with ejaculation reduces the risk of HIV and possibly other infections (IV, C).
- Insertive fellatio is lower risk than receptive (IV, C).
- Avoiding brushing teeth or flossing before having oral sex reduces risk of HIV and possibly other infections (III, B).
- Avoiding oral sex if oral cuts or sores are present, or a sore throat (IV, C)
- Using condoms for fellatio and dental dams for cunnilingus and oro-anal contact (IV, C)

Other Sexual Practices

No form of sexual contact is entirely without risk of STI transmission. Non-penetrative contact carries the lowest risk (IV, C).

In penetrative sex (including fingering, using sex toys and fisting) the risk of transmission is related to the degree of trauma. The use of gloves should be recommended for traumatic digital penetrative sex (IV, C).

Abstinence

The promotion of abstinence alone as a routine component of effective safer sex advice is not recommended (1a, A).

Partner Reduction

Safer sex advice should include discussion regarding reduction in number of partners or the number of unprotected sex partners, and in particular, the risks associated with concurrent partnerships in those at increased risk of HIV infection (III, B).

Advice should include reduction in the number of partners with whom the individual has oral sex (IIb, B with respect to syphilis in MSM).

Repeat Testing for STIs

Re-testing for asymptomatic STIs should be recommended to all individuals with a prior STI diagnosis including HIV (III, B).

Screening for asymptomatic STIs should be recommended at least annually (and in some cases as frequently as every three months) to all individuals at risk of acquisition or transmission of HIV (IV, C).

HIV testing should be routinely recommended to all individuals attending GUM or sexual health services. Pre- and post-test discussions and counselling support should be available (IV, C).

Hepatitis Vaccination

Advice on the sexual transmission of hepatitis A and hepatitis B and the availability of vaccination should be given to all those at elevated risk of acquisition.

Advice Specific to the Prevention of Sexual Transmission of HIV Infection

HIV Infectivity on Antiretroviral Therapy (ART)

Advice to people living with HIV, their sexual partners and those from groups with higher incidence of HIV infection should include:

Taking effective ART and having a quantitative plasma viral load below the limit of detection of currently available assays significantly reduces the risk of HIV transmission (Ia, A).

Despite routine undetectable plasma viral load measurements a residual risk of transmission is likely to exist (IIb, B).

This residual risk is likely to be higher for anal sex than for vaginal or oral sex (III, B).

The risks are increased with reduced ART adherence or the presence of STIs in either partner. The risks can be reduced by using condoms and having regular STI screens (IV, C).

Serodiscordant couples should receive detailed expert counselling and support on the transmission risks and other relevant issues (IV, C).

Initiation of ART to Reduce Transmission Risk

Discussion regarding the early initiation of ART to reduce the risk of HIV transmission should be considered as part of safer sex counselling for some people living with HIV (Ib, A).

Seroadaptive Behaviours Including Negotiated Safety, Serosorting and Seropositioning

Negotiated safety and serosorting should be discussed with those who are known or suspected to be unable or unwilling to maintain 100% condom use (IV, C).

MSM should be advised that serosorting is less effective than consistent condom use but more effective than non selective non-use in preventing HIV acquisition or transmission (III, B).

HIV positive MSM should be advised of the risk of acquiring other STIs, in particular *Lymphogranuloma venereum* and hepatitis C, through unprotected sex with other HIV positive men (III, B).

Post-exposure Prophylaxis Following Sexual Intercourse and Pre-exposure Prophylaxis

All individuals at increased risk of HIV acquisition (including those in serodiscordant relationships, MSM and those from, or with partners from, populations with high HIV seroprevalence) and those at risk of transmitting HIV should receive verbal and written advice on the indications for and availability of post-exposure prophylaxis for HIV following sexual exposure (PEPSE) (IV, C).

Male Circumcision

There is currently no public health evidence to recommend male circumcision (MC) as a strategy for HIV transmission reduction in the UK, either at a population or individual level (IV, C).

Evidence and Consensus Based Patient Advice Statements

Condom Advice

- Use a condom every time you have vaginal, oral or anal sex to minimise the risk of transmission of HIV and other sexually transmitted infections (Ia).
- Even if you don't use a condom every time, or for every type of sex, use one as often as possible – this is safer than not at all (IIb).
- Even if you occasionally did not use a condom, that does not mean it is not worth using a condom every time in future (IIb).
- Non-latex condoms are slightly more likely to break than latex condoms (Ia).
    - Use non-latex condoms if you have a latex allergy (or if you are using creams or treatments that damage latex condoms) (IV).
    - Some men prefer the feel of latex condoms and find that they are less likely to lose erection (IV).
    - Some men find latex condoms easier to put on (IV).
- Female condoms are at least as good as male condoms at preventing STIs (Ia).
- You get better at using condoms the more you practice (IIb).
- Practising opening and using a condom alone, and in the dark, might make it easier to do when you have sex (IV).
- Make sure you use a condom of the right size, as condoms are more likely to split if too tight (IIa).
    - The girth (circumference) may be more important than penis length (IIa).
    - A fitted condom is more likely to slip off during withdrawal (IIa).
- There is no need to use extra lubricant with condoms for vaginal sex – lubricant increases the chance that the condom will slip off (IIb).
- It isn't safe just to use a condom when you ejaculate (come) – infections including HIV can be passed on without ejaculation (IV).
- Using two condoms is NOT better than one as they are more likely to break (IV).
- To avoid common condom errors, make sure you:
    - Remove all the air from the condom before putting it on.
    - Hold the condom during withdrawal (pulling out).
    - Don't unroll it before putting it on.
    - Put on the condom before you start having sex.
    - If you put it on the wrong way by mistake, use another one - don't just flip it over.

For Anal Sex

- Ordinary condoms are no more likely than thicker condoms to break or slip off during anal sex (Ib).
- Put water based lubricant all over the condom and inside the anus, but not inside the condom, before anal sex (Ib).
- You can use female condoms instead of male condoms for anal sex: remove the ring at the end of the condom and place on the penis like a male condom (III).

For HIV

- Taking effective ART and having an undetectable plasma or blood HIV viral load significantly reduces the risk of HIV transmission during sex (Ia).
- Even with an undetectable viral load, there is still a small risk of HIV transmission. This is higher for anal sex than for vaginal or oral sex (IIb).
- Continuing to use condoms for vaginal, anal and oral sex will further reduce any remaining risk of transmission (IV).
- Poor adherence (missing doses of ART) may increase the risk of HIV transmission (III).
- If you are living with HIV, or you have partners who are or may be HIV positive, have an STI check at least once a year (IV).

Definitions:

Levels of Evidence

Level	Type of Evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomisation
IIb	Evidence obtained from at least one type of well-designed quasi-experimental study
III	Evidence obtained from well-designed, non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grading of Recommendation

Grade	Recommendation
A (Evidence levels Ia, Ib)	Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation
B (Evidence levels IIa, IIb, III)	Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation
C (Evidence level IV)	Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Sexually transmitted infection (STI), including human immunodeficiency virus (HIV)

Guideline Category

Counseling

Prevention

Risk Assessment

Screening

Clinical Specialty

Infectious Diseases

Internal Medicine

Nursing

Obstetrics and Gynecology

Pediatrics

Preventive Medicine

Urology

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Patients

Physician Assistants

Physicians

Guideline Objective(s)

To provide evidence based guidance for practitioners in Level 3 genitourinary medicine (GUM) services (Tier 5 in Scotland) on safer sex advice provided in sexually transmitted infection (STI) and human immunodeficiency virus (HIV) management consultations

Target Population

Persons believed to be at risk of poor sexual health outcomes

Interventions and Practices Considered

1. Sexual history to identify risk factors
2. Intensive multi-session, evidence based behaviour change interventions
    - Motivational interviewing
    - Computer-assisted interventions
    - Videos in waiting rooms
3. Safer sex advice
    - Tailored to individual's needs and understanding
    - Advice on use of male latex condoms and female condoms
    - Advice on oral sex and sexual practices
    - Hepatitis vaccination
    - Risk reduction techniques
4. Testing for sexually transmitted infections (STIs)
    - Screening for asymptomatic STIs
    - Human immunodeficiency virus (HIV) testing
5. Initiation of antiretroviral therapy (ART): post-exposure prophylaxis following sexual intercourse

Note: Male circumcision was considered but not recommended.

Major Outcomes Considered

- Human immunodeficiency virus (HIV) acquisition and transmission
- Sexual transmission of hepatitis A and hepatitis B
- Sexually transmitted infection (STI)
- Condom efficacy
- Risk reduction behaviour

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The guideline was developed by review of Cochrane Library, Medline, EMBASE and conference reports and existing guidelines from 2000-Week 40 2008. Following consultation main title searches and searches relating to seroadaptive behaviours and human immunodeficiency virus (HIV) transmission were repeated and updated to May 2011. Main title searches included keywords 'Condoms' (1762 citations), 'Behavioural interventions' and 'Motivational interviewing'. Other keyword searches included 'Sexual intervention', 'Intervention meta-analysis STI', 'Brief intervention sexual health', 'Safer sex behavioural intervention', 'CBT sexual health intervention', 'skill sexual', 'condom skill', 'STI prevention', 'combination prevention', safer sex, 'condom error/s', 'condom breakage', 'condom' and 'erectile dysfunction', 'female condom', 'partner reduction', 'abstinence', 'contraception', 'negotiated safety', 'serosorting', seroadaptive, 'testing in relationships', 'frequency AND rescreening', 'seminal viral load' and others.

'Oral sex', 'anal sex', 'digital', 'non-sexual', 'accidental', 'non-sexual' and 'kissing' were combined individually without mapping with sexually transmitted infections, HIV, syphilis, herpes, HSV, Chlamydia, gonorrhoea, warts. STI risk combined with 'sex workers', sex work, 'prisoners', 'looked after, accommodated, adolescents'. 'Sexual behaviour' combined with 'compulsion'. Title searches were used by individual co-authors to identify articles of relevance. Articles published in English only were included.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level	Type of Evidence
Ia	Evidence obtained from meta-analysis of randomised controlled trials
Ib	Evidence obtained from at least one randomised controlled trial
IIa	Evidence obtained from at least one well-designed controlled study without randomisation
IIb	Evidence obtained from at least one type of well-designed quasi-experimental study
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IV	Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Individual authors identified relevant articles by title search and examination of conference proceedings. Abstracts were examined for quality and relevance to the subject area and original papers were obtained for all included references. Detailed summaries of each subject area were prepared by co-authors and reviewed by the writing group, before editing to produce the Review of Evidence which accompanies the guideline. Following the consultation period the Review of Evidence was further edited to produce the final guideline.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Guideline development is undertaken by a multi-disciplinary writing committee with membership determined in a transparent manner. The chair is chosen by the Clinical Effectiveness Group (CEG). The CEG lead then discusses with the chair what suggestions they might have for members from other disciplines. The additional members of the group are then invited by the CEG. Writing committee membership includes relevant professional groups (for example genitourinary medicine physicians, nurses, health advisors, pharmacists, microbiologists and other professionals from allied specialities as appropriate) and when relevant this will involve working with the appropriate British Association for Sexual Health and HIV (BASHH) Special Interest Group (SIG) and the BASHH audit group.

Patients' views and preferences are sought and considered and the process documented. This may include patient representative involvement in the writing committee, information obtained from patient interview or surveys during the writing and/or piloting process, reviewing published work on patient experiences or involving patient associations. The chair of the writing group identifies an appropriate member such as the Health Advisor to get patient feedback on the guideline. BASHH is currently developing a public panel to assist with its work and in the future this group could be approached to assist in guideline development.

Recommendations are formulated with consideration of their health benefits, side effects and risks, with evidence presented in the guideline that these issues have been addressed. Each recommendation is linked to the supporting evidence with a list of relevant references.

Consideration is given to pragmatic and organisational issues relevant to the guideline. This is sought during and may emerge from the piloting of the guideline.

The authors consider the financial cost implications of recommendations made. Where disagreement arises within the writing committee with regard to recommendations the chair attempts to resolve these (for example by a voting system or formal consensus method). The process is documented and reported to the CEG editor. When this is not possible the CEG will review the evidence themselves and invite the chair and possibly other members of the writing committee to a meeting to agree a resolution and final recommendations.

Recommendations have been graded according to the level of evidence, utilising the US Department of Health and Human Services Agency for Healthcare Policy and Research (AHPCR) System.

Rating Scheme for the Strength of the Recommendations

Grading of Recommendation

Grade	Recommendation
A (Evidence levels Ia, Ib)	Requires at least one randomised controlled trial as part of the body of literature of overall good quality and consistency addressing the specific recommendation
B (Evidence levels IIa, IIb, III)	Requires availability of well conducted clinical studies but no randomised clinical trials on the topic of recommendation
C (Evidence level IV)	Requires evidence from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates absence of directly applicable studies of good quality

Cost Analysis

In men who have sex with men (MSM), meta-analysis shows that behavioural interventions to reduce sexual risk in MSM are cost effective, but there is limited cost effectiveness data directly applicable to other risk groups or other sexually transmitted infections (STIs). No data on the provision of interventions in genitourinary medicine (GUM) clinics or data comparing interventions in clinics with community based prevention interventions was found. Local protocols on the selection and prioritisation of candidates for various levels of intervention and the interventions provided should be based on the relative prevalence of infection in different risk groups outlined above, staff competency, training capacity and local financial constraints. There is sufficient evidence to recommend that access to intensive behaviour change interventions, at least for those at the highest risk of STI and human immunodeficiency virus (HIV), should be available in all GUM clinics.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The draft guideline was posted on the British Association for Sexual Health and HIV (BASHH) and British HIV Association (BHIVA) websites for a three month period. Comments were invited from (but not restricted to) BASHH and BHIVA membership and through third sector agencies and patient involvement groups. All comments and feedback were collated and grouped by theme, assessed by the writing group and changes made to the guideline. A list of groups and individuals proving consultation feedback was included in the published guideline.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is graded and identified for most recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate guidance on the content of safer sex advice and the format and delivery of brief behaviour change interventions deliverable in genitourinary medicine (GUM) clinics

Potential Harms

- Serosorting may be associated with a small decrease in the risk of seroconversion and is almost certainly safer than unprotected anal intercourse (UAI) with unselected partners but less safe than avoiding UAI altogether. It remains a controversial harm reduction technique and has been characterised as seroguessing because around 30% of men have been found to assume rather than know the status of partners. There is also evidence that there may be an increase in other sexually-transmitted infections (STIs) when serosorting occurs.
- Negotiated safety (NS) usually refers to the use or non-use of condoms according to a partner's human immunodeficiency virus (HIV) status. NS has been criticized as 'negotiated danger' and agreements must be detailed and specific if negotiated safety is to be an effective harm-reduction tool.

Qualifying Statements

Qualifying Statements

The recommendations in this guideline may not be appropriate for use in all clinical situations. Decisions to follow these recommendations must be based on the professional judgement of the clinician and consideration of individual patient circumstances and available resources.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Patient Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Clinical Effectiveness Group. UK national guidelines on safer sex advice. London (UK): British Association for Sexual Health and HIV; 2012 Jul. 32 p. [120 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2012 Jul

Guideline Developer(s)

British Association for Sexual Health and HIV - Medical Specialty Society

British HIV Association - Disease Specific Society

Source(s) of Funding

No specific or external funding was sought or provided in the development of this guideline.

Guideline Committee

Clinical Effectiveness Group (CEG)

Composition of Group That Authored the Guideline

Principal Authors: Dr Dan Clutterbuck, Consultant in Genitourinary & HIV Medicine, NHS Lothian/NHS Borders, Honorary Senior Lecturer, University of Edinburgh; Professor Paul Flowers, Professor of Sexual Health Psychology, Glasgow Caledonian University, Glasgow, UK; Dr Tristan Barber, Specialty Registrar in GUM/HIV, Mortimer Market Centre, NHS Camden, London UK (BASHH HIV Special Interest Group); Dr Ade Fakoya, Consultant Physician (BHIVA) (pre consultation draft); Heather Wilson, Senior Health Adviser, Barnet Hospital (BASHH, Society of Sexual Health Advisors); Dr Mark Nelson, Consultant Physician, Chelsea and Westminster NHS Foundation Trust, London, UK (BASHH HIV Special Interest Group); Dr Barbara Hedge, Consultant Clinical Psychologist, St Helens & Knowsley Hospitals (British Psychological Society's Faculty of Sexual Health and HIV); Dr Sylvia Kapp, Clinical Psychologist, Mortimer Market Centre, London (British Psychological Society's Faculty of Sexual Health and HIV) (pre consultation draft); Dr Ann Sullivan, Consultant Physician in Genitourinary & HIV Medicine, Chelsea and Westminster NHS Foundation Trust, London, UK (BASHH CEG) – Editor

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Financial Disclosures/Conflicts of Interest

None

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the British Association for Sexual Health and HIV (BASHH) Web site .

Availability of Companion Documents

The following are available:

- Clinical Effectiveness Group. British Association for Sexual Health and HIV (BASHH) and the British HIV Association (BHIVA). Review of the evidence for the UK national guidelines on safer sex advice. London (UK): British Association for Sexual Health and HIV (BASHH); 2012 Jul. 53 p. Electronic copies: Available in Portable Document Format (PDF) from the British Association for Sexual Health and HIV (BASHH) Web site .
- British Association for Sexual Health and HIV: framework for guideline development and assessment. London (UK): British Association for Sexual Health and HIV; 2010. 18 p. Electronic copies: Available in PDF from the BASHH Web site .

In addition, audit standards are provided in the original guideline document .

Patient Resources

The following are available:

- A guide to safer sex. Patient information leaflet. London (UK): British Association for Sexual Health and HIV; 2012 Jan. 2 p. Electronic copies: Available in Portable Document Format (PDF) from the British Association for Sexual Health and HIV (BASHH) Web site .
- A BASHH guide to safer sex. 2012. Available from the BASHH Web site .
- A BASHH guide to condoms. 2012. Available from the BASHH Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on April 29, 2014. The information was verified by the guideline developer on June 3, 2014.

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